



# PATIENT REGISTRATION FORM

Verified By: \_\_\_\_\_

DATE REC/ENTERED: \_\_\_/\_\_\_/\_\_\_

STAFF INITIALS: \_\_\_\_\_

APPOINTMENT TYPE/STAFF USE ONLY  MEDICAL  DENTAL

Riverside  Safe Harbor  Pearl Street  South End  Champlain Islands  GoodHEALTH  Winooski Family

**PATIENT INFORMATION** PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only

LAST NAME			FIRST NAME			MI								
STREET ADDRESS			CITY			STATE			ZIP					
SOCIAL SECURITY #			DATE OF BIRTH			HOME PHONE			DAY PHONE			CELL PHONE		
EMAIL ADDRESS						PREFERRED CONTACT METHOD <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT MESSAGE								
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union			RACE <input type="checkbox"/> African-American <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial			Primary Language if Not English: _____ Do You Need Interpreter Services? <input type="checkbox"/> YES <input type="checkbox"/> NO Ethnicity/Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic								
Primary Care Physician				AGRICULTURAL WORKER <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal				Are You a U.S. Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		FAMILY FINANCIAL INFORMATION Family/Household Size: _____ Household Income: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Annually <input type="checkbox"/> Biweekly <input type="checkbox"/> Refused <input type="checkbox"/> Monthly				
LEGAL SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			CURRENT GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER MALE (Female-to-Male/FTM) <input type="checkbox"/> TRANSGENDER FEMALE (Male-to-Female/MTF) <input type="checkbox"/> GENDERQUEER <input type="checkbox"/> OTHER <input type="checkbox"/> CHOOSE NOT TO DISCLOSE			SEXUAL ORIENTATION <input type="checkbox"/> STRAIGHT or HETEROSEXUAL <input type="checkbox"/> LESBIAN, GAY or HOMOSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> CHOOSE NOT TO DISCLOSE			As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.		
HOUSING STATUS Are You Homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO If homeless, are you: <input type="checkbox"/> Doubling Up (living with others) <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown														

**PREFERRED PHARMACY**

PHARMACY NAME	PHARMACY LOCATION
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**EMERGENCY CONTACT**

NAME	RELATIONSHIP	PHONE NUMBER
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**RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)**

Patient (18 years or older)  Custodial Parent  Guardian (proof of legal status required for treatment)

LAST NAME			FIRST NAME			MI					
STREET ADDRESS			CITY			STATE			ZIP		
DATE OF BIRTH						HOME PHONE					

<b>DENTAL INSURANCE INFORMATION</b>	<b>MEDICAL INSURANCE INFORMATION</b>
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<p><input type="checkbox"/> I currently have DENTAL insurance (see below)</p> <p><input type="checkbox"/> I currently DO NOT have DENTAL insurance</p> <p><input type="checkbox"/> I would like to apply for the SLIDING-FEE SCALE</p> <p>Dental Insurance Name: _____</p> <p>Policy/ID Number: _____</p> <p><input type="checkbox"/> I currently have secondary DENTAL insurance (see below)</p> <p>Dental Insurance Name: _____</p> <p>Policy/ID Number: _____</p>	<p><input type="checkbox"/> I currently have MEDICAL insurance (see below)</p> <p><input type="checkbox"/> I currently DO NOT have MEDICAL insurance</p> <p><input type="checkbox"/> I would like to apply for the SLIDING-FEE SCALE</p> <p>Medical Insurance Name: _____</p> <p>Policy/ID Number: _____</p> <p><input type="checkbox"/> I currently have secondary MEDICAL insurance (see below)</p> <p>Medical Insurance Name: _____</p> <p>Policy/ID Number: _____</p>
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## Consent for Treatment and Consent to Release Health Information

for Treatment, Payment and Health Care Operations

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### I. Consent for treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

### II. Consent to release of health information, including health/treatment records for treatment, payment and health care operations:

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHCB for the following purposes:

#### A. Use of health information by or for CHCB for treatment, payment, and health care operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including financial or quality assurance audits and/ or training.
- Payment for services provided by CHCB. CHCB is authorized to obtain payment for health care services and can provide health information to insurance companies, workers compensation insurers or other agencies that pay for health services, as identified in my CHCB registration form or other updated insurance information on file with CHCB.

#### B. Disclosure of health information to persons or organizations outside of CHCB for treatment purposes:

CHCB is authorized to provide all necessary health information as determined by CHCB, including information about treatment for substance use disorders to any of the following health providers if I am referred there for medical treatment:

- **Hospitals:** University of Vermont Medical Center (UVMC), Copley Hospital, Porter Hospital, Northwestern Medical Center, Central Vermont Medical Center (CVCA), Dartmouth Hitchcock Medical Center (DHMC)
- **Allergy:** Timberlane Allergy & Asthma Associates
- **Audiology:** Adirondack Audiology Associates
- **Cardiology:** CVCA, Central VT Cardiology, NWMC Cardio, DHMC Cardiology
- **Dermatology:** Dorset St. Dermatology, Four Seasons Dermatology
- **Gastroenterology:** VT Gastroenterology, Northwestern Medical Center
- **Home Health:** Bayada Home Health, UVMC Home Health & Hospice
- **Neurology:** DHMC Neurology, Neurological Associates of Burlington
- **OB/GYN:** Lake Champlain Gynecology, Maitri, VT Gynecology
- **Ortho:** NWMC Ortho, Mansfield Ortho
- **Oximetry:** Lincare
- **Pain Clinic:** VT Interventional Spine Center, VT Pain Management, UVMC Pain Management
- **Radiology:** CVMC Radiology, NWMC, Porter, Copley and VT Open MRI
- **Sleep Study:** VT Medical Sleep Disorder, UVMC Sleep Program
- **Urology:** DHMC Urology, Green Mountain Urology
- **Veterans** Veterans Administration Programs and Facilities
- **Physical Therapy:(PT)** PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Elite Health &

Wellness, Essex PT, Every Woman, Evolution Therapy & Yoga, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Injury & Health Management Solutions, Inspire PT, Island PT, Living Well Center for Integrated Health, Long Trail PT, On Track PT, Peak PT, Pelvic Health, Phoenix PT, Pinnacle PT, Rehab Gym, Transitions PT, Timberlane PT, Vasta PT, and Vermont PT.

- CHCB is authorized to provide all health information to other health providers or agencies not listed who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);

### III. Termination and restrictions of this consent:

I understand that I have the right to revoke this consent at any time, but revoking this consent will not affect any actions which were taken by CHCB in reliance on this consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: \_\_\_\_\_ if none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHCB may or may not agree to requested the restrictions. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed consent.

### IV. Assignment of Benefits

I hereby assign to CHCB any and all payments to which I am entitled under Medicaid, Medicare, or any health insurance policy for health care, behavioral health, psychiatry or dental health services rendered to me by CHCB. I further authorize CHCB to bill and receive payment directly from Medicaid /Medicare or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB

to give Medicaid / Medicare or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct.

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHCB will use my protected health information in accordance with privacy law.

I understand that the Community Health Centers of Burlington, Inc. may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements. I understand that e-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

Name of Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED